Select Committee on Transfer of Care Delays (Ambulance Ramping)

Submission by Cameron Johnson

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Introduction

My name is Cameron Johnson, and I am a paramedic with Ambulance Tasmania (AT). Whilst I have been with AT for some time now, my ambulance career started in 2002 in the United States. I completed the National Registry of Emergency Medical Technician - Paramedic (NREMT-P) program, and was a registered paramedic working in Lorain County, Ohio. Upon return to Australia, I worked for AT until 2011, when for family reasons, we moved to Adelaide, South Australia. I worked for the South Australia Ambulance Service until 2017, when the family returned to Tasmania to work. We have been here since.

I have also had employment with the Australian Defence Force (ADF), including two operational deployments. I consider this important, as it gives context to the issues and effects ambulance ramping has had on me and my family. Whilst my ADF service was uneventful, it did provide me with some comprehensive and unique training and experiences, and resilience to live and work under duress, in austere environments, with little or no support. For this reason, I consider myself able to tolerate an above-average level of stress and discomfort, and suitable for a career in the ambulance profession.

For full disclosure, I am a current Health and Safety Representative (HSR) and Union Delegate with the Health and Community Services Union (HACSU). I have been very active in the raising of concerns, participation in meetings and working groups and even the issuing of Cease Work Directions (CWD) and Provisional Improvement Notices (PIN) regarding Ramping.

My reason for this submission is the profound effect that Transfer of Care Delay (Ramping) has had on me psychologically, to the point I have engaged with a mental health professional for a few years now. This issue has evolved and taken many different forms throughout my career, from no ramping to the situation now where we are part of the hospital system. When I commenced this job in 2002, there was no ramping, and I distinctly remember being “delayed” at a hospital in Lorain County for *15 minutes* and the uproar that caused amongst the ambulance crews and supervisors on duty that day. The reason on that occasion was simply it being a busier day than normal, but it was one instance, on one occasion. Getting stuck at the hospital was never a consideration when deciding what to do with the patient, it was just which hospital was more appropriate for their needs.

Ramping in Tasmania, commenced after we moved out of the Royal Hobart Hospital Emergency Department (RHH ED) when it was located on Argyle Street, in 2007. At the old ED, patients were immediately handed over to nursing staff and transferred onto a hospital bed in the entry corridor - effecting an immediate handover. AT and ED staff used to call this corridor the “Llewellyn Ward” - after the state Health Minister, David Llewellyn. Ramping did not occur until we relocated to the

current Emergency Department site, now accessed off Liverpool Street (down the ramp). Overnight, ED staff refused to take handover of ambulance patients in the corridor if there were no ED cubicles available.

At first, there was a general agreement between ED and AT staff that ramping was unacceptable, and ambulances needed to handover so they could attend to 000 callers in the community. There was some angst at times, between the staff of each agency, however, it was generally a collegial relationship that was sympathetic to the mission of the ambulance service.

This collaboration didn't last long, however. With ramping counted in minutes at first, within a few months, ramping became counted in hours. Slowly, over the years, we have reached a condition where patients are now ramped in a defunct ward (Emergency Medical Unit H Block – EMH H, or the "Paramedic Ward") for, at times, the entirety of the paramedics shift. I am aware of one patient that has been ramped for 21 hours.

I have even been picked up by a taxi at the commencement of my nightshift at the Kingston Ambulance Station and taken to the ED to take over a ramped patient from the Kingston dayshift team.

Initially, ramping occurred at the RHH ED inside the entry corridor/s. When we experienced the COVID 19 pandemic, AT paramedics were allocated the first of two defunct wards to ramp in - to mitigate some safety issues around airborne transmission of COVID 19. This first ward, Emergency Medical Ward A (EMU A), had a capacity of 7 patients, and was subject to a PIN issued by me due to the lack of a Risk Assessment conducted by AT, despite months of asking them too. This was referred to WorkSafe Tasmania (WST) and resolved with an order to complete the Risk Assessment. Prior to this PIN, I issued a Cease Work Direction to AT staff when a shift was advised that EMU A did not have any functioning toilets and that staff would have to flush the toilets with buckets of water. The very first PIN that EMU A received from me was concerning the lack of a cleaning schedule and allocation of ancillary staff to assist in clearing rubbish (including clinical waste), soiled linen and general cleaning and disinfecting of the EMU A area. This PIN also was referred to WST and resolved (to an extent) via the review process.

There were several serious events (reported via the Safety Reporting and Learning System - SRLS) and at least one death inside EMU A. The death was publicised widely at the time.

No sooner after that incident, AT staff were relocated to the current location of EMU H. EMH H has a bed capacity of 11 (increased an extra 4 from EMU A), including a separate area for infectious

ramped patients. Despite this, infectious and non-infectious patients are cohorted together, mainly due to only 1-2 Transfer of Care Delay Paramedics (ToCD Paramedics) being rostered on at a time. These staff are on-road Paramedics and Intensive Care Paramedics that have volunteered to come into the hospital and work in the Paramedic Ward on overtime. Whilst some are qualified as Registered Nurses (not acting in that capacity however), most paramedics are not, and we do not have the base level of knowledge on hospital procedures, processes, and general nursing care. At times, this ward has had 11 patients to one paramedic - a patient-to-nurse ratio that wouldn't be acceptable in many hospital wards, let alone an area with vulnerable patients still being investigated for exactly what is wrong with them clinically.

I must mention at this point, before looking at several case studies, that the only real control measures we have in the Paramedic Ward (and previously, the corridors) are administrative. They include;

(a) The Risk Assessment - This document specifies care processes, infection control requirements, toileting procedures, manual task procedures, etc.
(b) *Clinical Management of Patients affected by Ambulance Patient Off Load Delay in the RHH ED Protocol* - This is a combined THS/AT protocol that specifies who, and under what conditions, is responsible for the patient, and what treatments are allowed or handover must occur. This document was in draft form from 2013, and only signed off when the RHH ED was issued a PIN by another HSR around 2018 and a crisis meeting was chaired by the current Secretary of Health involving all key personnel from the ED, AT and THS (SDMS ID# P20/198).
(c) Several emails to AT Southern Region paramedics from Regional Manager/Director David Horseman, in response to meetings with HSR's and HACSU delegates and Industrial Officers regarding urgent issues and agreed controlled measures.
(d) The Tasmanian *Work Heath Safety Act, 2012*.

Being administrative controls, at times (often), compliance is poor, and subject to biased intentions and misuse. Often, AT staff are coerced into breaching these control measures, due to bed block and the need for THS staff to commence "work up" of patients (take blood samples, perform x-rays, Computed Tomography or other diagnostics). This does not occur in other ambulance and health jurisdictions. After this is done, AT staff are then guilted into allowing the ED to commence treatments, sometimes complex and not within the clinical scope of a paramedic, in breach of the agreed protocol.

Staff have been "disciplined" by AT managers, and ED consultants for speaking up about breaches in protocol, or disallowing treatments to occur unless handover is completed. This has resulted in interpersonal conflict, adverse events for patients (allergies, anaphylaxis, overdose) and demonstrates that whilst these control measures are useful, compliance is poor and subject to the "human factor".

Scope of this submission

The scope I wish to look at in this submission is the Terms of Reference, particularly;

(b) the effect transfer of care has on:-

(i) patient care and outcomes, and,

(iii) wellbeing of healthcare staff, and,

(f) actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays.

I could address all the elements of the Terms of Reference, however I would rather concentrate on these above in particular, being a frontline paramedic, and having lived experience with caring for patients and attempting to make improvements through my role as an employee, HSR and union delegate.

I hope the following case studies help illustrate the multiple issues and complexities whilst ramped and inside the hospital corridors and Paramedic Wards and highlight some common themes that should guide any future actions taken. I have de-identified the patients and limited some circumstantial information as not to breach privacy.

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Case Study - Patient Y [redacted]

This incident occurred in 2018. We were dispatched to a 24YO patient (Patient Y) who had come off a motorbike and slid into a street sign. Patient Y collided with the sign with the upper leg (thigh) and bounced off. Whilst it wasn't obvious, we suspected Y had a fractured femur or pelvis. The patient was extricated from the scene utilising full spinal precautions and treated with intravenous fentanyl - a potent analgesic for their leg pain. We transported Y to the Royal Hobart Hospital and were ramped in the corridor immediately on arrival.

Because it was the end of our shift, I handed Y over to another paramedic that was commencing their nightshift. I conducted a verbal handover and passed on a copy of the electronic Patient Care Report (ePCR).

The next day, I was advised by the other paramedic that Y was subject to further fentanyl administration whilst ramped for pain, and then further analgesia from the hospital at the same time. However, no one had recorded how much fentanyl the hospital had administered, because they had not written it in the patient chart of Y. The only way the final amount administered to Y was determined was through reconciliation of the RHH Drug of Dependence book. The patient was subject to an adverse event through the administration of too much narcotic medication, by two separate agencies at the same time.

Luckily, patient Y recovered from this overdose.

Discussion

Whilst no one single person is at fault here, this case illustrates several key issues in providing clinical care inside a hospital hallway (or new Paramedic Ward) involving several teams. Firstly, when ramped, there can be several “handovers” for the one patient - firstly at triage, then on the ramp between AT teams or ToCD Paramedics, then interfering THS staff such as the Clinical Interventions Nurse (CIN – whose role is to commence diagnostic tests and any treatments whilst ramped) or a Medical Officer (usually an intern doctor, or junior Resident Medical Officer - who then communicates with a Specialist Consultant on a treatment plan for authorisation). Like a game of “Chinese Whispers”, it doesn’t take much to get a mixed message, or incorrect clinical history, or advice.

This incident also demonstrated that the hospital ramp is a dangerous place for patients. In this case it was poor documentation, in breach of the National Safety and Quality Health Service Standard (NSQHS) – Communicating for Safety. And there has been other breaches and inadvertent overdoses or adverse events prior and since involving narcotics, but also sedatives and antibiotics.

I had another patient administered the “clot-busting” medication, Tenecteplase, whilst ramped in the ED corridor last year. This patient was concurrently under the care of AT, RHH ED, and RHH Neurology staff. Whilst there was no adverse event on this occasion, this medication comes at great risk of uncontrolled bleeding, and administering it in the hallway, without basic or advanced life support equipment, is totally unacceptable.

Also, the Ramp (corridor or new Paramedic Ward) is a confusing space - who is in control? Who is responsible? It is clearly defined in the Clinical Management during Off Load Delay Protocol that if a ramped patient requires treatment outside of the AT paramedic scope of practice, handover MUST occur. Yet it doesn’t, and besides, this case study patient only got fentanyl, that’s within paramedic scope, right?

Correct, however AT paramedics working inside the hospital do not have ready access to Schedule 8 medication (such as morphine or fentanyl) and cannot access the RHH supply. So, they must involve ED staff in sourcing and administering the medication. Extra steps mean a further delay in care, but at worse, unintentional overdosing, or administration of incorrect medications or other complications.

And the result is extra stress which leads to a state of hyper-vigilance when taking patients to this ED. I will be honest; I get nervous when I am taking patients to this hospital, because the journey for them at the end is often confused, complicated, and hazardous.

Case Study - Patient Z

Patient Z was the responsibility of another ambulance team and arrived whilst I was ramped with my own patient at the RHH ED. I recall noticing that Z seemed confused, or maybe suffering from dementia, as they were trying to negotiate the ambulance stretcher seat belts, but were easily distracted by the attending paramedic. I recall they mentioned Z needed to be toileted and took them into Ramp Room 6 (a single room off the Ramp corridor used for interventions or diagnostic tests or other procedures requiring modesty whilst ramped). It was not long before I heard some screaming and a call for help.

I was sitting at the computer station in the ramp corridor immediately adjacent Ramp Room 6 and was shocked by what I was confronted with walking through the door; a half-naked patient lying on the floor, screaming in pain, and their foot was at right angles, with blood coming out from a compound (open) fracture. There was a large pool of blood on the floor and blood sprayed up the wall.

I immediately hit the wall-mounted duress button. Then grabbed the patient's foot, as it was unstable, and they were kicking it around in their confused state in obvious pain. We were assisted by some other THS staff to get Z off the floor and into the Resuscitation Room to commence his treatment for the compound fracture and whatever else Z was initially brought to hospital for.

To top off a very confronting, messy, stressful scene, when I returned to my own ramped patient, I passed Ramp Room 6 and saw a colleague cleaning up the blood with a box of tissues, because we have no access to proper cleaning supplies in the corridor. This broke my heart, and I think of this often. I assisted them in this task, and completion of the SRLS, and then went back to the Ramp - my own patient had been left unattended for quite some time whilst I was holding patient Z's foot on.

Discussion

This incident highlights further that the hospital is not a safe place for patients or paramedics at times, and that we are not trained in simple tasks like toileting patients, or to conduct a Falls Risk Assessment or other hospital manual tasks, outside of usual ambulance extrication techniques and equipment. The simple act of toileting a patient (who had either dementia or a head injury or some other confusion or delirium), on the edge of an ambulance stretcher, with no one to help, can only be described as hazardous in the least. If this patient was toileted in the back of the ambulance, they would not have been at risk of a full 1 metre fall (fully upright ambulance stretcher), and they would not have sustained the compound fracture.

Paramedics are still subjecting patients to this risk every day in the Paramedic Ward, despite the direction to get nursing assistance to help with these tasks. But because it takes time to summon a nurse, this is often not done.

Other ambulance services ramp inside ambulances, in the ambulance bay, and toilet patients inside the ambulance, or take them into a toilet cubicle on the ambulance stretcher (automated) and then return to the ambulance when done. There is no transfer to hospital stretchers, and no paramedics pushing hospital stretchers around the department - again, because the Medical Orderlies are already busy elsewhere. This risk of using unfamiliar equipment, together with a lack of trained assistance, or planning or proper Risk Assessments, places patients (and paramedics) in danger everyday this practice continues.

When responding to emergencies in the community, as a paramedic, you get 'psyched' for what you are going to - whether it is a near-drowning, motor vehicle accident, fall, stabbing, etc. Whilst often you get a little surprise, you can process and manage your emotions on a traumatic scene, make decisions, perform skills and concurrent tasks because you have had an opportunity to think and get into the mindset what you are required to do. This is our job as a paramedic. But this incident was troubling, as it was *inside* the hospital - which should be a safe place for everyone, with practiced and effective control measures. This caught me way off guard - like when something happens at home when you are least expecting it.

I have discussed this case with my psychologist as well, the effect on my wellbeing, and how to regard it going forward. It was a disturbing event, made all the worse by the subsequent management "fob off" of the SRLS, and no real supervision since to avoid it happening again.

But regardless, the root cause analysis of this incident is ramping. To prevent future injuries, illness and deaths whilst ramped, we need to eliminate this practice altogether.

Further Actions

Having experienced a career in ambulance spanning 22 years, going from no ramping at all, to entire shifts stuck inside a hospital (and often going home "sick"), I do have a few ideas on how to mitigate it as much as possible, if not eliminate it all together. I am on the current Transfer of Care Working Group, but the progress to date is slow, and I don't have any confidence that the other non-ambulance stakeholders want to pick up and address this issue either, so I fear this group will be ineffective. This issue needs leadership and direction from government.

The following are my suggestions to make meaningful, permanent change.

1. **Legislate a Ban on Ramping at any Health Facility in Tasmania.**

Make it illegal to ramp an ambulance, or any ambulance resource, including personnel, in or around any Tasmanian Health Facility, both public or private. Have an ambulance Triage Time of 5 minutes, and Patient Off-load Time of 30 minutes. Breaches subject to prosecution.

Unless it is legislated that ambulances can't be ramped, facilities such as the RHH ED, will always find an excuse to delay transfer of care, or force the ambulance service into actions to alleviate ramped crews such as is the current situation in the EMU-H Paramedic Ward. Having a KPI of 5 minutes to triage (reportable to Parliament if it is breached, like an Australian Triage Score Category 1 patient needing to be seen within 2 minutes at the hospital), then gives the hospital 25 minutes to locate an orderly, fetch a hospital bed, and transfer care to receiving medical staff.

To further enhance this course of action, all ambulances could pre-notify their arrival via GRN radio or phone, to optimise off-load opportunities. If helpful, ED Navigator RN's can have ambulance arrival dashboards installed for use (some are used already in Tasmanian hospitals, however not really for priority bed allocation or planning for surge in the ED).

Where the patient goes after arrival and handover is totally up to the hospital, and of no concern of the ambulance service. The hospital will find a suitable clinical space.

This legislation could also be extended to other emergency services workers, including Tasmania Police Officers who are often in the hospital Waiting Room awaiting blood analysis for suspects in

custody on suspicion of drink/drug driving, or escorting mental health patients due to Protective Custody (Detaining for Purpose of Assessment) or flight risk.

The problem of ramping will become that of the hospital, and whilst "kicking the can down the road" is not exactly ideal, the hospital will be more effective in fixing the issue, as they have the expertise and authority to manage the situation effectively. As it stands, AT cannot influence policy or procedure inside the hospital, and do not have the expertise to recognise, respond and manage hazards and risks effectively.

The hospital does and will. If that means more staff or beds available, better patient flow-through, better discharge options, better Surge Planning, more nursing home beds, utilising medi-hotels, or Hospital-in-the-Home, or a combination of measures, so be it. But it has nothing to do with Ambulance Tasmania at this point.

2. **KPI's for Ambulance Times at Tasmanian Health Facilities.**

Falling short of legislative powers, measurable and reportable KPI's for ambulance triage and off-load at all Tasmanian health facilities, public and private, will go toward greatly reducing the incidences of ramping from our current situation of being the worst in the country.

Often it can take 45 minutes to even be triaged, as there is only one triage nurse and they can be pre-occupied with booking in Waiting Room patients, so the ambulance waits. It's very frustrating when you are waiting for triage, only to put your patient into the waiting room, because they are low acuity and you just wanted to run it by the Triage Nurse to be respectful. So, there is 45 minutes of ramping, for no clinical reason what-so-ever.

So, a dedicated triage RN, 24/7 for ambulance arrivals, and absolute priority for ambulance patients to be handed over (to the Waiting Room or cubicle) within 30 minutes will half the ramping time as it currently stands. This alone will place us in the best position nationally, encourage paramedic recruitment and retention, and staff wellbeing. Most importantly, you have halved the time patients are exposed to ramping hazards and risk, as there is no more Paramedic Wards, or ramping in the corridor, and commencing hospital treatment further delaying allocation of a hospital bed.

3. **Robust Ramping Policy and Procedure (and training) of all Medical Staff during Induction.**

It seems that Tasmania hospitals employ a lot of transient (FIFO) medical staff who bring experiences from other jurisdictions, including different ramping processes and expectations. It needs to be clear that coercion of AT paramedic staff into commencing treatments whilst ramped is in breach of the current control measure; Clinical Management during Off Load Delay Protocol, and if this treatment is necessary, handover must occur. This is what happens in other jurisdictions, but somehow, someone at the THS (and to an extent, managers at AT) is happy to allow this breach daily, with most ramped patients.

This does differ between THS sites - for instance, the LGH Ramping Policy allows for hospital treatments to commence on ramped ambulance patients. However, this is also possibly why the LGH currently has the worst ramping statistics and longest times *in the nation*, and further proof that this is just making ramping worse, as it gives no incentive for ramped patients to be allocated an ED cubicle or be taken elsewhere into the hospital system.

Also, *Triage-by-Diagnostics* must cease - that is, making a patient an ATS Category 2, pending blood analysis and ECG (or x-ray or whatever other relevant diagnostic test is indicated). All this does is free up a Resuscitation bed that they would normally have these tests done immediately, but keeps an ambulance crew ramped for longer, because there is no real rush for the hospital staff to complete these actions and investigations urgently anymore. I have been ramped for two hours with as Category 2, only for them to go into the waiting room because the blood analysis was “ok”. Similarly, I have had sick Category 2 patients that have been ramped for two hours for Triage-by-Diagnostics, only to be confirmed as “sick” and finally handed over in a Resus Bay. These patients should be worked up in a Resuscitation Bay immediately, and transferred out as soon as it is indicated based on the science of blood gas analysis, ECG, etc.

Unfortunately, other measures such as giving the ED another $1.5million dollars (like a few years back) will be a waste of time if the current situation is not addressed to remove the “human factor”. Whilst staff are subject to workload pressures that cause them to cut corners or accept that the situation is hopeless or “unfixable”, ramping will be rife, and adverse patient outcomes will increase and wellbeing of staff will be eroded further. AT paramedics are already looking elsewhere, I know as soon as my wife can secure a job in the ACT, I will be applying for that ambulance service because they have ramping minimised and in a much more controlled environment through robust policy and a much better culture around this issue. I have seen paramedics leave this profession because of ramping, and if it wasn’t for my sessions with the psychologist, I probably would have left years ago too.

Thank you for the opportunity to participate in hopefully meaningful change for Tasmania’s Health system and emergency services. I hope this is effective in minimising or eliminating this abhorrent practice. Or in the least, making it a lot safer for all involved.

I would be happy to provide further examples or appear in person for any processes as part of this inquiry. I can be contacted on [redacted]